REFERRAL TO LOCAL CHILD SUPPORT SERVICES AGENCY (LCSSA)

(Complete one form for each Absent Parent or Alleged Father)

DATE OF REFERRAL

☐ TO LCSSA REPRESENTATIVE

CASE NAME | AID TYPE/CASE NUMBER

☐ FROM CWD REPRESENTATIVE CW # PHONE

APPLICANT/RECIPIENT NAME (LAST, FIRST, MIDDLE) | RELATIONSHIP TO CHILD(REN)

A. This case is referred to you because:

☐ Action is necessary to obtain:
- ☐ financial support ☐ medical support ☐ paternity

☐ Recipient is receiving direct support payments. Action needed to transfer payments to county.

☐ Good Cause has been (see CW 51 attached):
- ☐ claimed ☐ granted ☐ denied

☐ Other (see comments)

B. The following information applies to this case:

☐ CA 2.1(Q) Questionnaire is attached.

☐ Absent parent has health insurance coverage. A copy of the DHS 6155 is attached.

☐ Medi-Cal eligibility has not been determined.

☐ Previously sanctioned/penalized; now agrees to cooperate/assign support rights.

☐ Child no longer resides with recipient.

☐ Medi-Cal Only

☐ CS 909, Declaration of Paternity, is attached.

☐ Other (see comments)

C. Applicant/recipient has not agreed to:

☐ Assign:
- ☐ financial support rights ☐ medical support rights

☐ Cooperate in:
- ☐ obtaining financial support ☐ obtaining medical support and/or
- ☐ establishing paternity

☐ Forward support payments.

D. Penalty/Sanction

☐ Penalty has been applied due to non-cooperation.

☐ Sanction has been applied for refusal to assign rights.

☐ TO CWD REPRESENTATIVE CW #

☐ FROM LCSSA REPRESENTATIVE PHONE

☐ Applicant/recipient has cooperated with the law.

☐ Applicant/recipient has not cooperated with the law:
- ☐ Did not appear and/or provide verbal, written or documentary information
- ☐ Rescheduled appointment on _____ ☐ kept ☐ failed
- ☐ Refuses to appear as a witness at court or other hearing
- ☐ Refuses to transmit child support payment(s) received directly from the absent parent

☐ Other (see comments)

☐ This is a notice of renewed cooperation.

☐ Paternity ☐ has ☐ has not been established.

☐ Support order established.

☐ CS 909, Declaration of Paternity, is attached.

☐ Other (see comments)

E. TYPE OF APPLICATION

☐ NEW ☐ REAPPLICATION ☐ ADD A CHILD ☐ ICT ☐ RENEWAL

ABSENT PARENT'S OR ALLEGED FATHER'S NAME | CHILD SUPPORT FILE NUMBER

CHILD'S NAME | DATE OF BIRTH ☐ MFG RULE APPLIES

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F. ☐ APPLICANT PREVIOUSLY RECEIVED AID

SPECIFY TYPE: ☐ CASH AID ☐ MEDI-CAL ONLY ☐ TMC

PLACE (CITY, COUNTY, STATE) | DATE LAST RECEIVED

G. ☐ INTER-COUNTY TRANSFER/INTERSTATE TRANSFER

FROM (COUNTY/STATE) | PRIOR COUNTY'S CHILD SUPPORT FILE NUMBER (IF KNOWN)

H. ☐ CASH AID

APPROVAL DATE | ONGOING CASH AID AMOUNT $

DISCONTINUANCE DATE

REASON/CODE FOR DISCONTINUANCE

I. ☐ MEDI-CAL ONLY

DATE MEDI-CAL BEGINS/CONTINUES | DATE DISCONTINUED

REASON FOR DISCONTINUANCE

Comments: